February 1st, 2018

The Honorable Mia Costello
Chair, Alaska Senate Labor & Commerce Committee
State Capitol
Room 504
Juneau, AK 99501

Re: SB 112 (Giessel) – Support

Dear Senator Costello,

On behalf of ReedGroup, Ltd., owners of the Evidence-Based Medicine Practice Guidelines researched and developed independently by the American College of Occupational and Environmental Medicine (ACOEM), I write to advise that we support SB 112, and the adoption of the most recent version of ACOEM's Occupational Medicine Practice Guidelines as the standard to furnish medical care to injured workers throughout the State of Alaska.

My name is Carlos Luna, Director of Government Affairs for ReedGroup. I serve on the Research and Standards Committee, Disability Management and Return to Work Committee, and Medical Issues Committee for the International Association of Industrial Accident Boards and Commissions (IAIABC) and the Claims Administration Committee and Medical and Rehabilitation Committee for the Southern Association of Workers' Compensation Administrators (SAWCA).

Since 1981, ReedGroup has been a leading provider of EBM content and tools; our organization offers information and guidance focused on the therapeutic benefits of returning to work following a serious health condition. ReedGroup's EBM content and tools are used by clinicians, insurers, employers, healthcare organizations, and government agencies to guide important decisions on treatment, pharmaceutical drug prescriptions, rehabilitation, and return-to-work.

ACOEM represents more than 4,500 physicians and other health care professionals that specialize in occupational and environmental medicine (OEM), and is the nation's largest medical society that since 1916 has dedicated itself to promoting the health of workers through preventive medicine, clinical care, research and education.

While national in scope, the College is composed of local component societies in the United States and Canada, whose members hold scientific meetings and network on a regular basis. The Northwest Association of Occupational and Environmental Medicine, a member of the College,

established in 1956 and represents physicians and providers in Alaska dedicated to the ACOEM mission.

In 1993, ReedGroup expanded to become a Third-Party Administration company. Today ReedGroup serves 63 of the US Fortune 100 Companies and has grown to nearly 2,000 employees across the US, Canada, and India. We serve approximately 6M workers throughout the US who can potentially be impacted by work-related injuries and rely on adequate medical care and medications to support them in their recovery from injury or illness.

I ask you to approve the adoption of ACOEM's Evidence-Based Medicine Practice Guidelines as a standard of care for work-related injuries. I ask you not to subject workers in Alaska to the risks that accompany the over-utilization of treatment, inappropriate prescription of pharmaceutical drugs, resulting in prolonged absences from work and productive living.

Wide variations in medical care for similar health conditions have been identified as signs of quality issues. There is no quality evidence that this variability results in better patient care. In 2003, it was estimated that only slightly more than half of U.S. adults received medical management consistent with currently applicable recommendations.[1] Variations in diagnostic interpretations, and treatment approaches and methods, occur in many specialties. This may be a particularly acute problem in musculoskeletal medicine, in which there is wide overlap between common health and life problems (CHLPs) and serious medical conditions (SMCs). There are great differences in approaches to management for specific conditions such as low back pain among different health care financing systems; for example, medical care under workers' compensation systems uses many more resources, without evidence of better outcomes (see Systemic Factors). Improving the consistency of practice improves clinical quality, and congruity with the best available scientific evidence is clearly most desirable.

The original definitions of evidence-based medicine (EBM) focused on the care of individual patients, using evidence to improve outcomes. In a 1996 editorial in the *British Medical Journal*, Sackett defined EBM as "…the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients."[2] It was further noted that the practice "…means integrating individual clinical expertise with the best available external clinical evidence from systematic research."[2] As the field has matured, the focus of EBM has evolved toward the use of evidence of effectiveness to allocate resources to those tests and treatments that are effective and efficient, rather those that are not. In 2005, EBM was defined as "… a set of principles and methods intended to ensure that to the greatest extent possible, medical decisions, guidelines, and other types of policies are based on and consistent with good evidence of effectiveness and benefit."[3] Properly done, the use of EBM is a process which entails identification of high-quality

scientific evidence, as defined by rigorous criteria, and synthesis of the entire body of evidence applicable to a given condition to guide (not dictate) medical practice.

Please consider the following:

- A report published on March 3rd, 2016 by the California Workers' Compensation Institute (CWCI), California has experienced a decrease in Workers Compensation inpatient hospitalizations by 22.8% from 2008 to 2014.
- The report also assessed that the number of Workers Compensation implant-eligible spinal surgeries declined 8.4% in 2013 and 13.6% in 2014.
- The CWCI report sites that the decline "coincided with continued development of evidence-based medicine…" and indicates Payers of Workers Compensation claims saw fewer hospital stays than Medicare, Medi-Cal and Private coverage between 2013 and 2014.

The use of ACOEM's EBM Practice Guidelines has been correlated with improved quality outcomes and patient safety and decreased costs in general medicine.[4] The effectiveness of guideline use in reducing work disability (time off work, time on modified duties, and recurrences) in Australian workers with low back pain has also been demonstrated.[5]

ReedGroup's research over the past 4 decades indicates that the over-utilization of treatment and inappropriate prescription of pharmaceutical drugs directly impact the duration of the disability extending the recovery period for injured employees and therefore diminishing the potential of ever returning to work with each passing day.

Alaska's choice to adopt the most recent version of the ACOEM Occupational Medicine Practice Guidelines ensures that injured workers receive medical care for work-related injuries in accordance with the only nationally recognized workers' compensation evidence-based treatment guidelines source approved and listed by the federal Agency for Healthcare Research and Quality's National Guidelines Clearinghouse. ACOEM's Occupational Medicine Practice Guidelines are the only nationally recognized workers' compensation guidelines source that adheres to the National Academies of Sciences, Engineering, and Medicine's (formerly the Institute of Medicine) *Standards for Developing Trustworthy Clinical Practice Guidelines*.[17]

Adopting guidelines that meticulously align with the Standards for Developing Trustworthy Clinical Practice Guidelines ensures injured workers are treated according to standards that have been measures and found to be developed with:

1. Establishing transparency, explicitly detailing how guideline is developed and funded and making the information publicly accessible with;

2. Management of conflict of interest (COI), by requiring individuals being considered for membership into the Guideline Development Group (GDG) to declare, in writing, all interests and activities potentially resulting in COI with development group activity;

3. Guideline development group composition, which includes a balanced multidisciplinary panel comprising of a variety of methodological experts and clinicians with patient and public involvement;

4. Clinical practice guidelines systematic review intersection, using systematic reviews that meet the Institute of Medicine's Committee on Standards for Systematic Reviews of Comparative Effectiveness Research;

5. Establishing evidence foundations for and rating strength of recommendations, which includes an explanation of the reasoning underlying the recommendation with a clear description of potential benefits and harms, a summary of relevant available evidence (and evidentiary gaps), and consistency of the aggregate available evidence;

6. Articulation of recommendations, using a standardized form detailing precisely what the recommendation is and under what circumstances it should be performed;

7. External review, by a group of reviewers comprised of a full spectrum of relevant stakeholders, including scientific and clinical experts, organizations (e.g., health care, specialty societies), agencies (e.g., federal government), patients, and representatives of the public;

8. Updating, which includes regularly monitoring literature following the publication of the Clinical Practice Guideline (CPG) to identify the emergence of new, potentially relevant evidence and to evaluate the continued validity of the CPG.[18]

ACOEM's methodology draws upon the standards set by National Academies of Science, Engineering, and Medicine (formerly IOM), GRADE, AGREE and AMSTAR. These are nationally and internationally recognized standards used to create quality guidelines.

While I am speaking as an advocate for all those ReedGroup represents in the State of Alaska who are detrimentally affected by the absence of a nationally recognized EBM standard of care, I also have direct experience with having consulted many employers, physicians, insurers, healthcare organizations, and government agencies over the past decade.

Thank you for the opportunity to address this very important matter.

Sincerely,

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Systemic Factors

Overview of the Workers Compensation System:

Workers' compensation systems represent a dynamic balance among the sometimes aligned and sometimes competing interests of businesses seeking affordable costs of care and restored worker productivity; affected workers demanding adequate and timely medical care and other benefits as specified by law; and insurers attempting to secure reasonable profits for cost coverage and other services provided.[6] Workers' compensation has been described as "social" insurance, concerned with both the adequacy of disability benefits (i.e., no-fault payments with statutory minimums) and system efficiency (in terms of reduction of costs to all parties involved, including the affected worker, employer, insurer, and system itself).[7] This entity has been described as a "health care payment system within the legal system."[8] It has also been noted that the system is unique among government "social" programs in that it operates (in most states) as a partnership between the public and private sectors, with legislatures establishing rules by statute; executive branches providing oversight, regulation, and dispute resolution; and the private sector (insurers and self-insured employers) administering the system on a day-to-day basis.[9]

In the majority of affected workers, these systems may facilitate the process of return to former levels of health and function after work related illness or injury, particularly in those who are motivated to do so. However, the same systems may provide significant and sometimes difficult barriers to rehabilitation and disability prevention. For affected workers who experience medical, personal, psychological, or socio-cultural factors or workplace factors, or who are not motivated to return to work, these systems can provide both barriers to recovery and perverse incentives which in the short term rewards work disability at the long-term expense of employers, payers, and society. Various forms of moral hazard encountered in workers' compensation systems, including positive correlation between maximum benefit and claim frequency, the Pareto distribution of claims (including a 3 to 6-fold incidence of repeat claimants in the highest consumers of benefits), and preferential classification of claims as work related in health maintenance organizations have been described.[7] A qualitative study of workers' compensation claimants in Ontario identified numerous subtle system-level problems which can accumulate into a "toxic dose" providing significant and sometimes insurmountable barriers to return to work.[10] The legal system is intended to protect affected workers from potential lapses or abuses by the health care system, employers and payers, and often does so, but claimant resort to this system may entail similar incentives that can reward work disability in direct proportion to its extent and severity in susceptible individuals. Finally, the societal economic and employment climate may affect worker motivation to return to work as well as participation in and response to the workers' compensation and legal systems.

A detailed discussion of the controversies surrounding systemic factors, including workers' compensation systems and their legal components, is beyond the scope of the current chapter. The remainder of this section will present evidence for suboptimal system performance and some clinical concerns, and provide some general recommendations for physicians caring for individuals involved in workers' compensation cases.

Concerns about Workers Compensation:

The ACOEM statement, *Preventing Needless Work Disability by Helping People Stay Employed*,[11] addresses a number of concerns about current workers' compensation system processes from the physician perspective:

- Although physicians play an important role in the return to work process, they are typically given too little information to act effectively. Employees often are the physicians' only source of information because employers usually do not send any information to the physician about an employee's functional job requirements, their stay-at-work/return-to-work programs, their commitment (or lack of it) to employee well-being, or how to quickly answer questions or address problems.
- Claim administrators often request information from physicians to help in managing their claim. They tend to use a generic approach that does not match the information requested with the simplicity or complexity of the situation. Questions often seem designed to determine eligibility for benefits rather than to find a way to help employees return to work.
- Discussion of affected worker functionality, which is not subject to confidentiality restrictions, lacks sufficient focus. Employers and claims administrators often find it easier and more efficient to send volumes of material to physicians instead of reducing the available information to the essential questions for the physician's convenience.
- Many physicians seem unaware of employers' and benefit administrators' needs for information. When physicians receive poorly conceived requests for guidance or opinions, they have little tolerance or time to review irrelevant or redundant information to find the few useful pieces of data.
- Many physicians simply do not know how their delays or inadequate responses impact optimal functional outcomes for their patients.
- There is little or no standardization of communication methods, particularly paper and electronic forms, among stakeholders.

Interviews with 402 workers with back injuries and workers' compensation system involvement in Florida and Wisconsin found some positive interactions with the system; however, the workers' overall experience was negative.[12] The authors posited three aspects of workers' compensation insurer behavior to explain this experience:

- The perceived suspicion that many injured workers are undeserving beneficiaries of the workers' compensation system, which the authors suggest reflects a common belief among insurers that many workers' compensation claims are fraudulent.
- Insurer tactical behavior, whereby payments are delayed to pressure workers to return to work quickly, discourage medical care provision by worker-chosen physicians, or to affect the worker bargaining positions for negotiated settlements.
- Failure of insurers to pay required payments promptly due to their own system deficiencies.

Based on a study of 1,472 workers' compensation claimants with low back pain, the validity of the entire disability determination process for this condition was questioned.[13] The authors noted very weak associations (all r values <0.10) between affected worker final disability ratings and post-settlement pain, distress, or disability or occupational status; disability rating shared only 3% of its variance with the outcomes. They questioned the utility of the disability ratings "beyond the administrative function of bringing closure to a protracted medico-legal process."[13] A somewhat different viewpoint has also been presented.[14] The authors described a number of positive correlations between compensation benefits and claims incidence (e.g., 10% increase in benefits associated with 1 to 11% increase in claim number and 2 to 11% increase in claim duration) suggesting a significant moral hazard associated with workers' compensation. However, they note a number of alternative explanations for this effect, including the nature of claimant work; demographic factors such as age, gender, education level, social class, and immigrant status; differing occupational, economic, and societal influences; and different selection and referral patterns. They noted that 75 to 95% of claimants respond well to health care and return rapidly to work, and that secondary losses usually outweigh secondary gains in those who do not.

Recommendations for Physicians:

Physicians can exert only limited control over systemic factors, and there are few if any interventions that can be affected by physicians. A phenomenon termed "non-credible health care" has been described and noted that workers' compensation systems "simply do not provide the safeguards against non-credible care that are inherent in many major medical insurance systems, Medicare, Medicaid, and especially in socialized medicine in other countries."[15] Some of the clinical practice factors relevant to avoiding non-credible health care and facilitating system performance include:

- A focus on work disability prevention and management.
- Appropriate evidence-based medical practice, including:
- Appropriate interpretation of diagnostic testing.
- Avoidance of mischaracterization of affected worker conditions (particularly CHLPs), overemphasis on specific diagnosis (escalating case time and costs), and overtreatment (escalating case time and costs and potentially exerting negative psychological effects on workers).
- Avoidance of specific practices known to have harmful effects, such as the unnecessary use of opioids and work restrictions.
    - Optimization of physician-worker interaction.
    - Maximization of communication with other stakeholders, particularly employers and payers (including required regulatory paperwork), to facilitate diagnostic and therapeutic interventions and return to work, and minimize time delays.

A report on a dedicated workers' compensation PPO in Louisiana, described positive effects of the organization in both affected worker lost time days and costs.[16] The authors attributed the differences to the use of experienced physicians and other providers trained in case management; care coordination by occupational physicians; early case management; and diagnostic and therapeutic intervention based on medical indication, not third party approval. They concluded that all four elements were necessary for the outcomes they achieved, but concluded that the managing care physicians and case managers were integral to the positive results. This may provide some guidance – and inspiration – for physicians (and other stakeholders) in dealing with the vicissitudes of the present systematic influences on affected worker outcomes.

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